TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MMC of East Texas

Respondent Name
Norguard Insurance Co

MFDR Tracking Number
M4-16-0616-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requestor appealed the Carrier's determination on the date of 07/09/2015 with all documentation required to show prior authorization was not obtained from GALLAGHER BASSETT due to services were initially billed to and paid by the patient's medical carrier. Following this Request for Reconsideration, the Carrier maintained its original determination. It was the Carrier's contention that the "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT."

Amount in Dispute: $8,941.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2014	Outpatient Hospital Services	$8,941.24	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 18 – Procedure code was invalid on the date of service
   - 197 – Precertification/authorization/notification absent
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification /authorization/notification absent." 28 Texas Administrative Code §134.600 (p) (2) requires that

   > Non-emergency health care requiring preauthorization includes:
   >
   > (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

   Review of the submitted information finds insufficient evidence to support prior authorization was obtained. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

2. The carrier states "The Requestor appealed the Carrier's determination on the date of 07/09/2015 with all documentation required to show prior authorization was not obtained from GALLAGHER BASSETT due to services were initially billed to and paid by the patient's medical carrier." 28 Texas Administrative Code 134.600 (c) states,

   > The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:
   >
   > (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   >
   > (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   >
   > (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
   >
   > (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
   >
   > (D) when ordered by the commissioner; .

   Review of the submitted documentation finds insufficient evidence any of the above were met in this dispute. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.